

Medical Assistance Administration



Healthy Options/Basic Health Plus/ Children's Health Insurance Program Health Care Plans

**Instructions for Supplemental Billing,
Rebilling
& Adjustments**

October 2003

About this publication

This publication supersedes all previous Medical Assistance Administration (MAA) Healthy Options Licensed Health Carrier Billing Instructions.

Additional information regarding MAA medical care programs, eligibility and limitations can be found in the MAA General Information Booklet.

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Important Contacts

A provider may use MAA's toll-free lines for questions regarding its program. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. [WAC 388-502-0020(2)].

Where do I call for information on becoming a DSHS provider, submitting a provider change of address or ownership, or to ask questions about the status of a provider application?

Call this toll-free number:
(866) 545-0544

Where do I send my claims?

Division of Program Support
PO Box 9246
Olympia WA 98507-9245

Where can I view and download MAA's Billing Instructions or Numbered Memorandum?

Go to MAA's web site:
<http://maa.dshs.wa.gov>
(Click on Provider Publications/
Fee Schedules)

Where do I call if I have questions regarding...

Payments, denials, general questions regarding claims processing, or Healthy Options?

Medical Assistance Customer Service
Center (MACSC)
(800) 562-6188

Healthy Options/BH+/CHIP contract issues?

Please contact the appropriate MAA Contract Manager. You may call (360) 725-1642 for the name and telephone number of the MAA contract manager for each plan or check the Healthy Options page on MAA's web site (<http://maa.dshs.wa.gov/healthyoptions>).

Private insurance or third party liability, other than Healthy Options?

Coordination of Benefits Section
(800) 562-6136

Internet Billing?

<http://maa.dshs.wa.gov/ecs.htm>

Definitions

The section defines terms and acronyms used in this booklet.

Basic Health (BH) – The health care program authorized by title 70.47 RCW and administered by the Health Care Authority (HCA). [WAC 388-538-050]

Basic Health Plus (BH+) – A program jointly managed by the Health Care Authority and the Medical Assistance Administration (MAA) for BH enrollees who are eligible for Medicaid (notably children and pregnant women). BH+ offers the expanded benefits available in the Healthy Options/MAA benefit package and allows family members in BH to remain together in the same managed health care plan rather than being on two separate plans under BH+ and HO. Pregnant BH+ enrollees are also referred to as “S” medical enrollees.

Centers for Medicare & Medicaid Services (CMS) - The agency within the federal Department of Health and Human Services (DHHS) with oversight responsibility for the Medicare and Medicaid programs. Formerly known as the Health Care Financing Administration (HCFA). [WAC 388-500-0005]

Children’s Health Insurance Program (CHIP) – the federal Title XXI program under which medical care is provided to uninsured children under age 19:

- (1) Whose family income is between 200 and 250% of the federal poverty level; and
- (2) Who are not otherwise eligible under Title XIX of the Social Security Act. [WAC 388-500-0005]

Client - An individual who has been determined eligible to receive medical or health care services under any MAA program. [WAC 388-500-0005]

Code of Federal Regulations (CFR) - Rules adopted by the federal government. [WAC 388-500-0005]

Community Services Office (CSO) - An office of the department's Economic Services Administration (ESA) that administers social and health services at the community level. [WAC 388-500-0005]

Core Provider Agreement - The basic contract between MAA and an entity providing services to eligible clients. The core provider agreement outlines and defines terms of participation in medical assistance programs. [WAC 388-500-0005]

Department - The state Department of Social and Health Services (DSHS). [WAC 388-550-0005]

Dual Coverage - When an MAA client is enrolled with the same health care plan both through Medicaid and another insurance contract (i.e., through employer of spouse, parent, guardian or Medicare).

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.
[WAC 388-500-0005]

Federally Qualified Health Center (FQHC) –

- 1) A facility that is receiving grants under section 329, 330, or 340 of the Public Health Services Act; or
- 2) A facility that is receiving such grants based on the recommendation of the Health Resources and Services Administration within the Public Health Service, as determined by the Secretary to meet the requirements for receiving such a grant, OR
- 3) A tribe or tribal organization operating outpatient health programs or facilities under the Indian Self Determination Act (PL93-638).

Only CMS-designated FQHCs under a current contract with a Healthy Options, BH+, or contracted healthcare plan are allowed to participate in the managed care program.

Fee-for-Service - A payment method MAA uses to reimburse providers for covered medical services provided to medical assistance clients, except those services provided under MAA's prepaid managed care programs. [WAC 388-500-0005]

Healthy Options (HO) - The Medical Assistance Administration's (MAA) prepaid managed care health program for Medicaid-eligible clients and CHIP clients.
[WAC 388-500-0005]

Managed care - A comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. These services are provided either through a managed care organization (MCO) or primary care case management (PCCM) provider.
[WAC 388-500-0005]

Managed care organization - A health maintenance organization or health care service contractor that contracts with DSHS under a comprehensive risk contract to provide prepaid health care services to eligible medical assistance administration (MAA) clients under MAA's managed care programs. [WAC 388-500-0005]

Medicaid - the state and federally funded Title XIX program under which medical care is provided to persons eligible for the:

- (1) Categorically needy program; or
 - (2) Medically needy program.
- [WAC 388-500-0005]

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI state-children's health insurance program (S-CHIP), Title XVI, and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.
[WAC 388-500-0005]

Medicaid Management Information System (MMIS) – The information system used by MAA to indicate clients' eligibility and managed care enrollment status, to pay claims, and for other information.

Participating Provider - A person or entity with a written agreement with an MCO to provide health care services to managed care enrollees. A participating provider must look solely to the MCO for payment for such services. [WAC 388-538-050]

Patient Identification Code (PIC) - An alphanumeric code assigned to each MAA client consisting of the client's:

- a) First and middle initials (or a dash (-) if the middle initial is not indicated).
- b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- c) First five letters of the last name (or spaces if the name is fewer than five letters).
- d) Alpha or numeric character (tiebreaker).

Primary care case management (PCCM) - A system under which a provider contracts with the state to furnish case management services, which include the provision, coordination and monitoring of primary care to Medicaid clients. [WAC 388-500-0005]

Primary Care Provider (PCP) –a person licensed or certified under Title [18](#) RCW including, but not limited to, a physician, an advanced registered nurse practitioner (ARNP), or a physician assistant who supervises, coordinates, and provides health services to a client or an enrollee, initiates referrals for specialist and ancillary care, and maintains the client's or enrollee's continuity of care. [WAC 388-538-050]

Provider - Any person or organization that has a signed contract or core provider agreement with DSHS to provide services to eligible clients. [WAC 388-500-0005]

Remittance and Status Report (RA) - A report produced by the Medicaid Management Information System (MMIS) [MAA's claims processing system] that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Rural Health Clinic (RHC) - A certified clinic that is located in a rural area that is designated as a shortage area and is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases. Only Department of Health (DOH)-certified RHCs under contract with a Healthy Options or BH+ contracted health care plan are allowed to participate in the managed care program.

Supplemental Payment - A payment billed by the Healthy Options, BH+, or CHIP health care plan or a qualified FQHC/RHC clinic that has *not* been prepaid by the MAA premium payment system.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical care client. [WAC 388-500-0005]

Voluntary County – A county where only one plan is available, due to either limited contracting, or insufficient capacity in the plans' networks of providers to serve all the potential Healthy Options enrollees in the county. Clients have the choice of enrolling in Healthy Options or remaining in fee-for-service.

Washington Administrative Code (WAC)
Codified rules of the State of Washington.

Health Care Plans

Who should use these billing instructions?

The Medical Assistance Administration (MAA) makes monthly premium payments in advance to health care plans (also called “plans” or “managed care organizations”) for clients enrolled in Healthy Options (HO), Basic Health Plus (BH+), and Children’s Health Insurance Program (CHIP). Plans must follow these billing instructions when billing for supplemental payments such as retroactive newborn premiums or enhancements to premiums already paid by MAA.

Billing Time Limits [Refer to WAC 388-502-0150]

You must submit your final billing to MAA within one (1) year of the end of the month in which the service was provided (e.g., a supplemental premium for October 2002 must be submitted by October 31, 2003).



Note: These instructions address how to bill for services covered by MAA that are the contractual responsibility of the health care plan. Noncontract services are billed on a fee-for-service basis using the billing instructions written for the specific type of service provided. Go to MAA’s web site at <http://maa.dshs.wa.gov/Download/publicationsfees.htm> to view MAA’s other publications.

Charts/Records [Refer to WAC 388-502-0020]

Providers participating in a plan must:

- Keep legible, accurate, and complete charts and records to support/justify the services provided to each client;
- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains; and
- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for six years following the date of service or longer if required specifically by federal or state law or regulation.

Third Party Resources

Providers must maintain records substantiating that all third-party resources (TPR) available to MAA clients have been identified and pursued. Providers must report all information that is not listed on the TPR quarterly report to MAA's TPR program:

**Coordination of Benefits
Division of Customer Support
PO Box 45561
Olympia WA 98504-5561
or call 1-800-562-6136**

Billing

Retroactive Newborn Premiums That Are Not Automatically Generated

When the mother is enrolled in Healthy Options, BH+, or CHIP, medical coverage is effective on the baby's date of birth. MAA pays retroactive newborn premium payments up to the end of the month in which the 60th day of life occurs. MAA pays a full month's premium regardless of the newborn's date of birth during that month. Premiums are usually automatically generated. If they are not, the plan must submit claims for them. Read the description for both below:

Automatically generated premiums

Retroactive newborn premiums are automatically generated by the MAA payment system for newborns meeting the following criteria:

- The baby's parent(s) informed the local Community Services Office (CSO) of the baby's birth and the child receives a Patient Identification Code (PIC) within one year of birth; and
- The newborn is linked to the mother's plan.

These premiums appear on the plan's Remittance and Status Report from MAA for HO and CHIP clients, and from the Health Care Authority for clients in BH+.

Retroactive premiums that must be billed

(Bill using HCPCS code **T2022** with modifier **HA**)

MAA cannot retroactively generate more than one year of premiums for newborns. MAA gives plans a monthly listing indicating the months for which MAA's payment system was unable to generate a premium. The plan must submit a claim for retroactive newborn premium for these months. MAA's payment system is not capable of automatically making retroactive premium payments for newborns without a PIC.

Using Mother's Patient Identification Code (PIC) for Newborns (Bill using HCPCS code T2022 with modifier HA)

There may be situations when it is not possible to obtain the baby's PIC. In these situations, the plan may use the mother's PIC to bill retroactive newborn premiums. The plan may bill under the mother's PIC for retroactive premiums on a newborn up to the end of the month in which the 60th day of life occurs, if appropriate. Bill premiums for only those months when both mother and baby were eligible. **Justification is necessary and must be noted on the HCFA-1500 claim form.**

Indicate the baby's name in *field 2* and the baby's birth date in *field 3*. Enter the mother's PIC in *field 1a* and the mother's name in *field 4*.

The following statements are acceptable justification for billing a newborn on the parent's PIC:

- "B" — Left state (before baby had PIC);
- "B" — Adopted/foster care on (month/year);
- "B" — Died (month/year) (before PIC issued); or
- "B" — DOB>6 mo. (never had PIC).

Enter one of the above statements in field 19 under Reserved for Local Use.

Bill premiums for only those months when both mother and baby were eligible. For example, if a baby is born and adopted in January, MAA allows no February premiums.

In an effort to avoid duplicate payments, MAA reserves the right to override the justification given by the plan and deny the claim if the baby's PIC is available. The denial reason will be indicated on MAA's Remittance and Status Report.

Delivery Case Rates

(Bill using CPT code **59409** or **59514**)

- If a woman is enrolled in HO, BH+, or CHIP at the time of delivery, MAA pays for the delivery only if the plan bills a delivery case rate (DCR) procedure code. The date of service in *field 24* must be the date of delivery. The woman must be enrolled with the plan at the time of delivery in order for the plan to bill for a DCR.



Exception: If the date of service for the hospital admission and the delivery date of service occur during two different, consecutive months, **and** the woman has changed plans during this time, enter the admission date in *field 24A*. Enter the date of the hospital admission and discharge in *field 18* with the actual delivery date indicated in *field 19*. If billing electronically, enter the hospital admission date in the *Comments* field. When this occurs, the plan that the woman was enrolled in when she was admitted to the hospital is responsible for the woman's and newborn's entire hospital stay. The new plan must coordinate discharge planning. If the woman is fee-for-service at the time of admission, MAA is responsible for hospitalization and delivery. No DCR is paid to the plan.

Example: The woman is enrolled with plan "A" for 11/01/03– 11/30/03 and with plan "B" for 12/1/03 - 12/31/03. The woman begins labor on 11/30/03 and is admitted into the hospital. The client delivers on 12/01/03. Plan "A" is responsible for the entire hospital stay and will receive the Delivery Case Rate (DCR). Plan "A" must enter the hospital admission date in *field 24A* as the date of service in order to be paid by MAA, since the woman is not enrolled in the plan on the day of the delivery. The date of the hospital admission and discharge must be indicated in *field 18* with the actual delivery date in *field 19*.

These dates are necessary because if plan "A" bills for 11/30/03 and plan "B" bills for 12/01/03 but neither plan shows justification, MAA considers the date of the newborn's birth as the correct date for the DCR. Thus, the DCR payment will be incorrectly paid to plan "B."

Note: The retroactive newborn premium is paid to the plan the mother is enrolled with at the time of delivery, regardless of whom is responsible for the delivery and hospital costs.

- Abortion, either spontaneous or induced, is not considered a delivery.
- If there are multiple births, only one delivery case rate is paid. However, MAA pays newborn premiums for *each* of the babies.

To avoid overpayments, plans must not bill for the DCR until the enrollee's provider verifies that the woman has delivered.



Note: It is important that the plan maintains legible, accurate, and complete charts/records to support/justify the DCR. These charts/records must be made available to MAA or its agents upon request. MAA will initiate a recoupment if there is a discrepancy over the DCR.

BH+ Maternity “S” Supplements

(Bill using CPT code **59899**)

If a woman is enrolled in BH+ and is on the “S” Pregnancy program, the BH plan may bill MAA for a supplemental payment. See the Delivery Case Rates section.

FQHC/RHC Enhancements

FQHC/RHC clinics are eligible to be paid by MAA for an enhancement for HO clients assigned to their clinics. The billing is based on a DSHS payment system tie between the plan and the FQHC/RHC. This tie is established by the plan notifying DSHS of a contract between the FQHC/RHC and the plan. The required documentation is a copy of the contract signature page between the FQHC/RHC clinic and the plan (including the effective date).

Please send the signature page to:

FQHC/RHC Healthy Options Contract Manager
MAA/DPS/MCCM
Post Office Box 45530
Olympia, WA 98597

Or Fax to:
FQHC/RHC Healthy Options Contract Manager
(360) 753-7315

Plans must notify DSHS in writing within 30 days after a contract with a FQHC/RHC is newly established or terminated. Written notification is mailed or faxed to the address above.

NOTE REGARDING NEWLY ESTABLISHED FQHC/RHC (s):

DSHS will notify plans by e-mail as clinics are newly designated as an FQHC or RHC.

FQHC/RHC Reports

On a monthly basis, the Healthy Options managed care plans will send a FQHC/RHC monthly report to MAA. The clinics will be paid on the number of HO, CHIP, BH+ and SMED clients that are on the monthly report.

The reports will contain the following information:

- Plan Number (Healthy Options/BH+ number)
- FQHC/RHC Number
- FQHC Name
- Eligibility Month (Current eligible month)
- Client full name (Last, First, and Middle Initial)
- PIC
- SSN (optional)

The due date of the report is by close of business, the last working day of the first full week of the reporting month.

For additional information, contact the FQHC/RHC Healthy Options Contract Manager at:

FQHC/RHC Healthy Options Contract Manager
MAA/DPS/MCCM
PO Box 54430
Olympia, WA 98597

FQHC/RHC Delivery Case Rates

(Bill using CPT code **59409** or **59514** with modifier UC)

If the client is in a HO/BH+/CHIP program and is enrolled with an FQHC/RHC at the time of delivery, and the FQHC/RHC performs the delivery, the qualified FQHC/RHC is eligible to receive a FQHC/RHC Delivery Case Rate (DCR) enhancement payment.

To bill for the FQHC/RHC DCR, the plan or the FQHC/RHC must submit an HCFA-1500 claim form using procedure codes 59409 or 59514 with modifier UC. The appropriate FQHC/RHC provider number (beginning with 759) must be indicated in field 33 (GRP#) and the plan provider number (beginning with 750) must be indicated in field 26 (Patient's Account No.). The enhancement amount will be paid directly to the FQHC/RHC.

FQHC/RHC BH+ Maternity “S” Supplements

(Bill using CPT code **59899** with modifier UC)

If a woman is enrolled in BH+ and is on the “S” Pregnancy program and is enrolled in an FQHC/RHC and receives her maternity and delivery services from this organization, the plan or the FQHC/RHC clinic can submit a separate claim using CPT code 59899 with modifier UC. Indicate the appropriate FQHC/RHC provider number (beginning with 759) in field 33 (GRP#) and the plan provider number (beginning with 750) in field 26 (Patient’s Account No.). The enhancement amount will be paid to the FQHC/RHC.

NOTE: If the woman’s PCP is with the FQHC/RHC, but the woman receives her prenatal services from a provider who is not part of the FQHC/RHC, do not bill for the supplement.

Example: For a plan/clinic to receive all possible payments for BH+ enrollees enrolled in managed care through an FQHC/RHC, the plan or clinic must submit two claims:

Claim #1, use:

- CPT code 59409 or 59514 (DCR) and CPT code 59899(BH+ maternity supplement) with
- Plan provider number next to GRP# in field 33; and
- FQHC/RHC provider number next to P.I.N.# in field 33.

Claim #2, use:

- CPT codes 59409 or 59514 with modifier UC (FQHC/RHC delivery case rate); and
- CPT code 59899 with modifier UC (FQHC/RHC BH+ maternity supplement); and
- FQHC/RHC provider number next to GRP# in field 33.

Please refer to the previous section on the Delivery Case Rates (DCR) for directions about which date of service to use.

Procedure Codes

To bill MAA, use the procedure codes listed below. See HCFA-1500 claim form instructions, field 24D.

Procedure Code	Modifier	Official CPT or HCPCS Description	Previous State Unique Description
T2022	HA	Case management, per month.	Monthly Retroactive Premium for Newborns
59409		Vaginal delivery only (with or without episiotomy and/or forceps)	Delivery Case Rate
59514		Cesarean delivery only	Delivery Case Rate
59409	UC	Vaginal delivery only (with or without episiotomy and/or forceps)	FQHC/RHC Delivery Case Rate
59514	UC	Cesarean delivery only	FQHC/RHC Delivery Case Rate
59899		Unlisted procedure, maternity care and delivery	BH+ Maternity Supplement
59899	UC	Unlisted procedure, maternity care and delivery	FQHC/RHC BH+ Maternity Supplement (Note: Only to be billed if the prenatal care provider is part of the FQHC/RHC.)

Key to Modifiers

HA = Child/adolescent program

UC = Medicaid level of care 12, as defined by each state.

For MAA's purposes, this modifier signifies FQHC/RHC billing.

Important Notice!!

Effective October 2003, the Health Insurance Portability and Accountability Act (HIPAA) requires all healthcare payers to process and pay electronic claims using a standard set of procedure codes.

MAA is discontinuing the state-unique codes used in this billing instruction and will require the use of applicable CPT and HCPCS procedure codes on all submitted claims.

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

Important!

General Guidelines:

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, faxed, or laser printer generated) HCFA-1500 claim forms.
- **DO NOT use red ink pens, highlighters, “post-it notes,” stickers, correction fluid or tape** anywhere on the claim form or backup documentation. The scanning process does not pick up red ink or highlighter and can actually **black out** the information. Do not write or use stamps or stickers that say, “REBILL,” “TRACER,” or “SECOND SUBMISSION” on the claim form.
- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch). Use all the same character fonts on the same claim form. Do not mix fonts or use italics or script.
- **Use upper case** (capital letters) for all alpha characters.
- **Use black** printer ribbon, ink-jet, or laser printer cartridges. **Make sure ink is not too light to be legible.**
- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.
- **Place only six detail lines on each claim form.** MAA does not accept “continued” claim forms. If more than six detail lines are needed, use additional claim forms.
- **Show the total amount for each claim form separately.** Do not indicate the entire total (for all claims) on the last claim form; **total each claim form.**

<u>Field</u>	<u>Description</u>
--------------	--------------------

- | | |
|-----|---|
| 1a. | <p><u>Insured's I.D. No.:</u> Enter the alphanumeric MAA Patient Identification Code (PIC) assigned to each client insured by Medical Assistance. This information is located in the client's monthly Medical Identification card and consists of the client's:</p> <ul style="list-style-type: none"> First and middle initials (or a dash (-) if the middle initial is not indicated) Six-digit birthdate, consisting of <i>numerals only</i> (MMDDYY) First five letters of the last name An alpha or numeric character (tiebreaker) <p>Use the mother's PIC code only if the newborn has not been issued a PIC and enter one of the appropriate reasons in field 19 (see field 19 instructions).</p> |
| 2. | <p><u>Patient's Name:</u> Enter the last name, first name, and middle initial of the MAA client.</p> |
| 3. | <p><u>Patient's Birthdate:</u> List the month, day and year of birth. If newborn, use date of birth.</p> |

- | | |
|------|--|
| 19. | <p><u>Reserved For Local Use:</u> If a newborn has not been issued a PIC, use the mother's PIC code (in field 1a) and enter one of the following statements (whichever applies and applicable dates):</p> <ul style="list-style-type: none"> Family left state before baby had a PIC Baby adopted/Foster Care on: (month/date) Baby died (month/year) before PIC issued Baby's DOB > 6 mo. and never had PIC |
| 24A. | <p><u>Date(s) of Service:</u> Enter the numerical month, day, and year of service in this format: October 1, 2003 to October 31, 2003 = 100103 - 103103. If newborn, use the date of birth through the end of month. Do not use dashes (-) or slashes (/) to separate month, day, and year. For the delivery case rate/enhanced/supplemental and enhancements, follow the directions given under "delivery case rates."</p> |
| 24B. | <p><u>Place of Service:</u> Enter a <i>11</i> for place of service.</p> |
| 24C. | <p><u>Type of Service:</u> Not required.</p> |
| 24D. | <p><u>Procedures, Services or Supplies CPT/HCPCS:</u> Enter only the appropriate procedure code from <i>page 12</i> of these billing instructions.</p> |
| 24E. | <p><u>Diagnosis Code:</u> Enter diagnosis code V68.9 (unspecified administrative purpose).</p> |

**HO/BH+/CHIP Supplemental Billing/
Rebilling & Adjustments**

24F. **\$ Charges:** Enter the appropriate supplemental premium payment amount under your contract. Do not use dollar signs (\$) or decimals (.).

24G. **Days Or Units:** Enter the number *I* to indicate one unit for each line.

26. **Patient's Account No./
Plan Provider Number**

A. Patient Account No: (**Not Required**) This is an alphanumeric entry up to 13-digits that you may use as your internal reference number. You create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report under the column headed "Medical Record Number." (Note: you might consider using this number to separate various accounts associated with your office, such as the accounts in different branch offices.)

B. Plan Provider No.: (**Required for FQHC/RHC Enhancement claims only**) Enter the 7-digit plan provider number (beginning with 750xxxx) directly after your internal reference number (as listed above) if entered.

For electronic claims, your internal reference number cannot be used. This field cannot exceed nine digits for electronic claims processing. If you choose to include your internal reference number in this field, you must submit hard copy claims.

28. **Total Charge:** Enter the sum of your charges. Do not use dollar signs (\$) or decimals (.).

30. **Balance Due:** Enter total charges. Do not use dollar signs (\$) or decimals (.).

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #:** Enter the name, address, and telephone number of the service provider, as recorded with MAA.

P.I.N.: If applicable, enter the performing provider number of the FQHC/RHC with which the client is enrolled.

Group: (Required for FQHC/RHC Enhancement claims)
Enter the 7 digit "Pay To" provider number of the FQHC/RHC (beginning with 759XXXX) assigned to you by the Division of Customer Support when you signed your Core Provider Agreement (unless instructions specify otherwise). This is the seven-digit provider number that appears on the Remittance and Status Report received with reimbursement for services. Please use this number on all forms and inquiries.

PLEASE
DO NOT
STAPLE
IN THIS
AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE <input type="checkbox"/> (Medicare #)		MEDICAID <input type="checkbox"/> (Medicaid #)		CHAMPUS <input type="checkbox"/> (Sponsor's SSN)		CHAMPVA <input type="checkbox"/> (VA File #)		GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/>		FECA BLK LUNG (SSN) <input type="checkbox"/>		OTHER (ID) <input type="checkbox"/>		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)								3. PATIENT'S BIRTH DATE MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>				4. INSURED'S NAME (Last Name, First Name, Middle Initial)															
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Recoupments

Supplemental Security Income Eligible Clients

For enrollees retroactively determined by the Social Security Administration (SSA) to be eligible for supplemental security income (SSI) benefits prior to calendar year 2003, MAA will recoup the premiums paid to HO/CHIP/BH+ plans for the period the enrollee was eligible for SSI during 2002.

If HO/CHIP/BH+ plans recover the amounts paid to providers for services during the correct time period, plans must inform providers how to rebill MAA.

MAA providers may bill MAA fee-for-service (FFS) for care rendered during the SSI eligibility period. The providers must send FFS claims for covered services to the MAA claims processing address appropriate for the claims.

For services not covered by MAA or that are outside MAA's normal billing guidelines (such as authorization requirements or restrictions), the claims should be submitted as instructed above. These claims will be individually handled by MAA.

Providers have 365 days from the date of service to bill MAA FFS. If the 365-day limit has expired, providers must bill MAA within 365 days from the date payments were recovered by the HO/CHIP/BH+ plans to establish timeliness.

When billing MAA beyond the 365-day limit or for non-covered services, providers must indicate the following in the appropriate field on their claim:

What to Indicate?

1. The health plan code (e.g. MHC, GHC, etc.)
2. The statement, "Due to SSI eligibility", and
3. The date the payment was recouped.

Where to Put the Above?

1. On HCFA-1500 claim form.....In Field 19
2. On UB-92 claim form.....In Field 84
3. If billing electronically In the Remarks Field

Example (Field 19 or 84)

19. CHPW SSI Recoupment 10/09/02

Plans should encourage providers who are not currently enrolled as MAA providers to obtain an MAA provider number by calling 1-866-545-0544 in order to be reimbursed.

Rebilling and Adjustments

This section explains how to correct any billing problems you may experience. It also explains how the rebilling and adjustment processes are different, and when to use them.

How long do I have to rebill, modify, or adjust a claim?

- Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.



Note: MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period except provider overpayments.

- The allotted time periods for billing and adjustments do not apply to provider overpayments that must be refunded to DSHS. See “How to Adjust Overpayments.”

Rebillings

Rebill when:

- **The claim is denied in full.** When the entire claim is denied, check the Explanation of Benefits (EOB) code, then make the appropriate corrections (see below) and resubmit your claim on a regular billing form, not the adjustment form.
- **An individual line is denied on a multiple-line claim.** The denied service may be submitted as a rebill on a regular billing form, not an adjustment form.
- **The claim is returned under separate cover.** Occasionally, MAA is unable to process your claim and will return it to you with a letter stating what information is needed. Correct the information as directed and resubmit your claim.

How to Rebill

- Check any EOB code listed, then make your corrections on a copy of the claim OR produce a new claim with the correct information.
- Attach insurance information to the corrected claim, and send it to MAA.



Note: Remember to line out or omit all lines that have already been paid on the claim before sending it back to MAA. Be sure to adjust the total.

If you rebill the claim after the billing time limit has expired, or more than 365 days from the original date(s) of service on the claim, **enter the 17-digit claim number in field 22 (HCFA-1500) or in the claim area (UB92).** This claim number is proof of your timeliness. Providers have 36 months from the date of service to rebill their claims, except for prescription drug claims.



Note: If 60 days (or more) have elapsed since you sent your claim to MAA *and* it has not appeared on your Remittance and Status Report, resubmit your claim.

Adjustments

Adjust the claim only when:

- **The claim was paid, and an error was made** in procedure codes, diagnoses, units, or anything else that may affect payment. Send MAA an Adjustment Request Form [DSHS 525-109] indicating corrections. Download this form at: <http://www.wa.gov/dshs/dshsforms/forms/eforms.html>

Mail to:

**Medical Assistance Administration
PO Box 9245
Olympia, WA 98507-9245**

- **The claim was overpaid.** See how to adjust claims on next page.

(See the Multiple Premium Payment Adjustments section for third-party liability.)

What form do I use for adjustments?

All **adjustments** must be submitted on the **Adjustment Request form [DSHS 13-715]**. Use only *one* adjustment request form per claim. Submit multiple line corrections to a single claim on one adjustment request form. Adjustments are processed in two steps:

1. The MMIS will locate the claim you wish to adjust. The message *CRE* will appear in the EOB column on the MAA Remittance and Status Report.
2. Usually the action requested is completed and the claim processed accordingly. However, requesting an adjustment does not necessarily mean that your claim will be paid. The adjusted claim may be denied if the original disposition was correct or if the information provided on the Adjustment Request is incorrect or incomplete.

Be sure that proper documentation is attached to your adjustment request (operative reports, Remittance and Status Reports, etc.) to avoid an incorrect disposition of your claim.

Note: When using this form to adjust premiums due to incorrect client information (e.g., wrong gender, birthdate, etc), the corresponding information first needs to be corrected at the community service office (CSO). If you submit information to your program manager, the information will be verified by the client and changed at the CSO before MAA will make a claim adjustment.

How to Adjust Overpayments

- Submit an adjustment: MAA will recoup your claim and deduct the excess amount from your future remittance check(s) until the overpayment is satisfied;
OR
- Issue a refund check payable to DSHS: Attach a copy of the Remittance and Status Report showing the paid claim and include a brief explanation for the refund (e.g., insurance payment, duplicate payment).

Mail this to:

**Finance Division
PO Box 9501
Olympia WA 98507-9501**

- After the allotted time periods, a provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check—not by claim adjustment.

**Submit an adjustment –OR- refund by check.
Do not send both an adjustment and a refund for the same claim.**

How to Complete the Adjustment Request Form [DSHS 13-715]

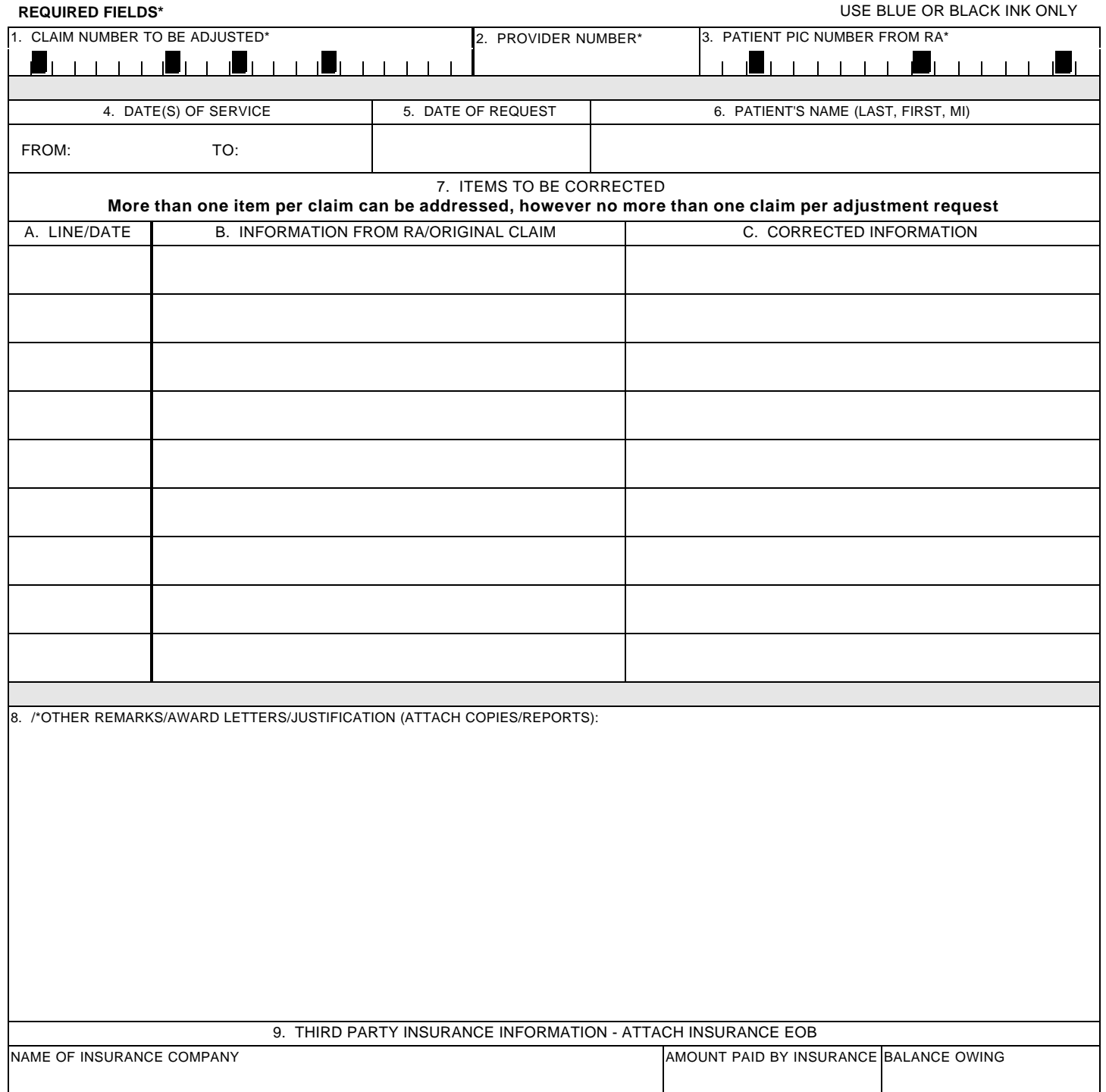
Use the Adjustment Request Form [DSHS 13-715] for all correction requests. The numbered blocks on the form are referred to as *fields*. Complete the fields as explained below, using the exact information from your Remittance and Status Report.

FIELD # DESCRIPTION

- | | |
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| <p>1. <u>Claim Number to be Adjusted:</u>
Required. Enter the 17-digit number from the claim to be corrected. Submit only one adjustment request per claim number.</p> <p>2. <u>Provider Number:</u> Required. Enter the MAA assigned 7-digit provider number as shown on the Remittance and Status Report.</p> <p>3. <u>Patient PIC from Remittance and Status Report:</u> Required. Enter the client's Patient Identification Code as shown on Remittance and Status Report.</p> <p>4. <u>Date(s) of Services:</u> Enter the beginning and ending dates of service for the <i>entire</i> claim, not just the line item to be corrected.</p> <p>5. <u>Date of Request</u> – Enter the date this form is being filled out.</p> <p>6. <u>Patient's Name:</u> Enter the client's last name, first name, and middle initial.</p> | <p>7. <u>Items to be Corrected:</u></p> <p>7A. <u>Line/Date:</u> Identify the line number of date of service to be corrected.</p> <p>7B. <u>Information From RA/Original Claim:</u> Identify the incorrect information from the RA/original claim.</p> <p>7C. <u>Corrected Information:</u>
Specify the correct information to be applied to the claim, use of field 8 may be required to clarify.</p> <p>8. <u>Other Remarks/Justification/Award Letters/Approvals</u></p> <p>This space is for any additional information pertaining to the reason for the adjustment. Attach a copy of the award letter, a copy of the Medical ID card, or approval, if necessary, for MAA to properly process the adjustment. (When attaching copies, <u>do not staple in the bar area.</u>)</p> |
|--|--|

9. **Third-Party Liability Information/Payment/Denial:** If a claim was paid or denied by other insurance sources, attach a copy of the EOB from the insurance company *and* the Remittance and Status Report.
10. **Provider Name and Address:** Enter your phone number. Enter your name and address as shown on the Remittance and Status Report.

DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Division of Program Support
PO Box 45560
Olympia, WA 98504-5560



10. PROVIDER NAME AND ADDRESS

DIVISION OF PROGRAM SUPPORT
PO BOX 45560
OLYMPIA, WA 98504-5560

MHCP Multiple Premium Payment Adjustments [DSHS 06-126]

The MHCP Multiple Premium Payment Adjustment Form (DSHS 06-126) is intended for use by plans when several months of premium payments are being adjusted for the same client. This may occur when:

- An enrollee disenrolled from the plan but MAA continued to pay premiums, or
- A third party is involved, creating *dual coverage*. (See Definition section for dual coverage.)

Download this form at: <http://www.wa.gov/dshs/dshsforms/forms/eforms.html>

This form may be used to adjust up to six claims for the same client.

Instructions for Completing the Premium Payment Adjustment Form:

- Enter in the top portion of the form:
 - ☐ The date.
 - ☐ The provider's name and address.
 - ☐ The provider number assigned by MAA.
 - ☐ The provider's telephone number.
 - ☐ The client's PIC code (from the client's medical ID card).
 - ☐ The client's name.
- Enter in each box (**use a separate box for each claim**):
 - ☐ The claim number to be adjusted.
 - ☐ The dates of service (from and to).
 - ☐ The amount to be adjusted for each claim.
- Indicate the reason for the adjustment at the bottom of the form.

These adjustments will appear on the MAA Remittance and Status Report. Using this method of making adjustments will provide the plan with a record showing that these overpayments have been recouped.

If the FQHC or RHC has received an enhancement, then these payments must also be recouped.



1. Please complete the entire form.
2. All information requested is necessary to process adjustment.
3. Enter data from MAA Remittance and Status Report.
- 4. Use black ink.**

Mail completed form to:
DIVISION OF PROGRAM SUPPORT
NON-INSTITUTIONAL ADJUSTMENT UNIT
PO BOX 9245
OLYMPIA WA 98507-9245

DSHS 06-126 (11/1994) (AC 11/2000)

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